

**PATIENT**

Cassie Grimm

SPECIES

Canine

BREED

Australian Shepherd

SEX

Spayed Female

AGE

9 Years

WEIGHT

40.8 Pounds

INTERPRETED BYBeth Johnson, DVM
DACVIM**IMAGING PERFORMED BY**

Amy Mayhew, LVT

HOSPITAL NAME

SVS Imaging MI

REFERRING VET

Hamilton AH

INVOICE

42479

DATE

10/28/22

PRESENTING CLINICAL SIGNS

Weight loss, bloody diarrhea, vomiting- Has had chronic GI signs in past was on GI Biome. Switched to z/d now.

Abnormal PE/Chem/CBC/UA Results: Muscle wasting. P does have a chronic open wound on abdomen from previous spay- feels like metal sutures that are causing the wound to continue to stay open and ooze. Owner aware surgery needed to remove the metal sutures but waiting on vomiting/diarrhea/weight loss to improve prior to anesthesia 4dx HWT neg fecal with giardia neg CBC-MPV 8.4 CHEM- WNL

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**Urinary System**

The urinary bladder is moderately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The right kidney is normal in size (5.37 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal in size (4.81 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

The right adrenal gland is normal in size (0.56 cm at the caudal pole, cranial pole not fully visualized), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.68 cm at the cranial pole and 0.72 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with very echogenic reverberation artifact from intraluminal gas. There is no evidence of

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obstruction, foreign material or infiltrative disease; however, complete visualization of far wall is partially inhibited by gas. Pyloric outflow tract appears patent.

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The visible small intestine demonstrates areas of thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. The lumen is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction or foreign material noted.

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The visible colon is normal in wall thickness (< 0.2 cm) and layering. It is moderately dilated with soft stool and gas.

Pancreas**SEX**

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The pancreatic parenchyma is appropriately isoechoic to surrounding tissue. Visible capsule is smooth and normal in contour. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen**AGE**

9 Years

There is no evidence of free peritoneal effusion noted in these images.

The mesenteric medial iliac lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail. The left medial iliac lymph node measures 0.38 cm thick. The right medial iliac lymph node measures 0.50 cm thick.

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ULTRASONOGRAPHIC FINDINGS**INTERPRETED BY**Beth Johnson, DVM
DACVIM

- **Inflammatory bowel disease (IBD) pattern** – Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No aggressive lymphadenopathy, loss of layering, etc. is noted to make lymphoma more probable, but lymphoma cannot be definitively ruled out without tissue sampling.
- **Reactive mesenteric and medial iliac lymph nodes** – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- **The colon is distended with soft stool** - Consistent with this patient's reported diarrhea.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

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Given the hematochezia, a fecal exam is recommended if not recently evaluated, as is a fecal enteropathogen PCR panel to Texas A&M GI Laboratory.

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In the meantime, empirical deworming with a 5-day course of Panacur is recommended as is the addition of probiotic such as Provable or Visbiome, and a diet change could be considered to a fiber response/colitis diet, or an alternative hydrolyzed protein diet such as a Purina or Royal Canin product, as some patients don't respond well to one hydrolyzed diet versus the other.

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Ultimately, biopsies of the GI tract via upper and lower endoscopy/colonoscopy may be necessary to definitively diagnose and therefore adequately manage the underlying cause of this patient's clinical signs.

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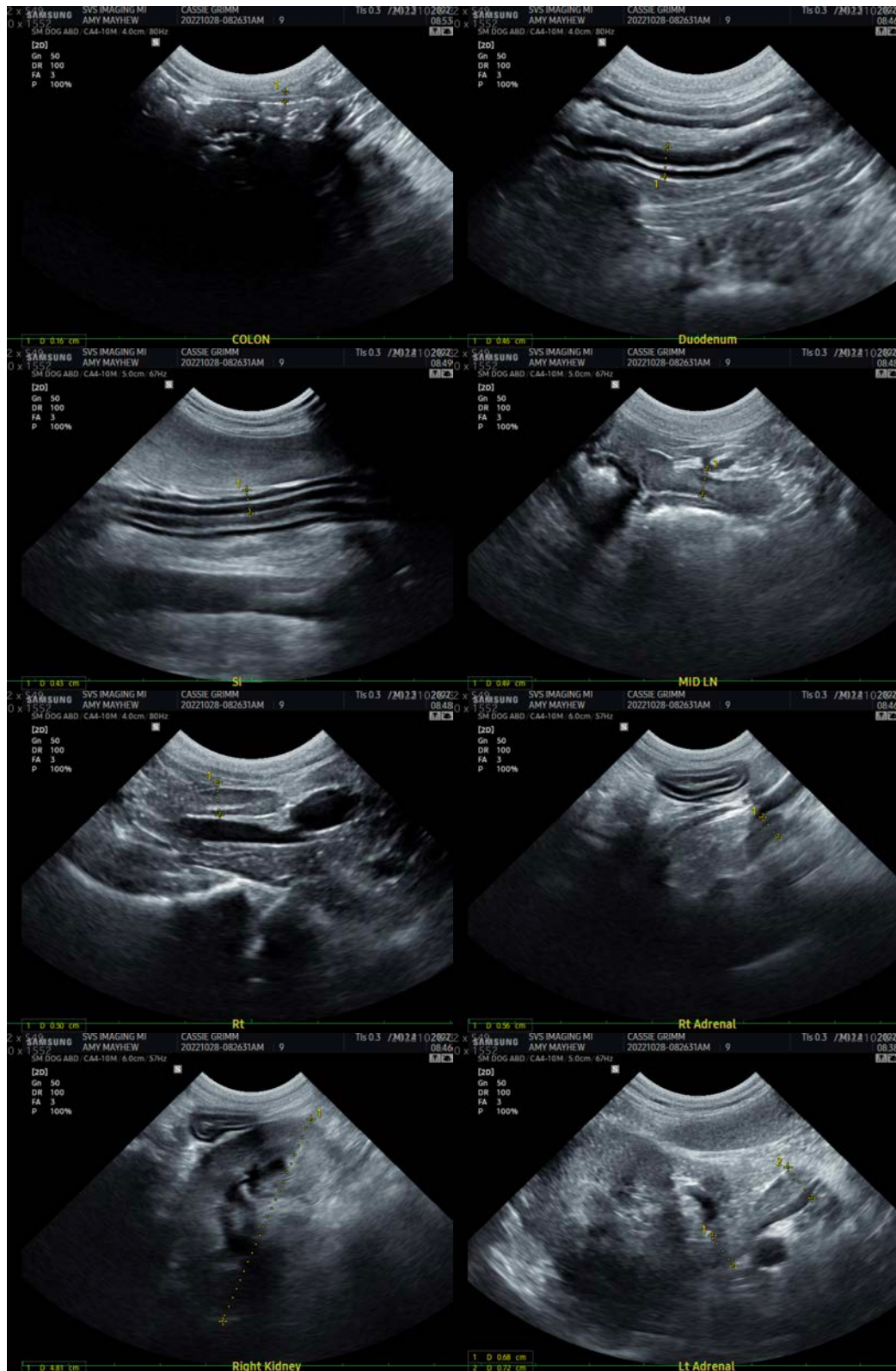
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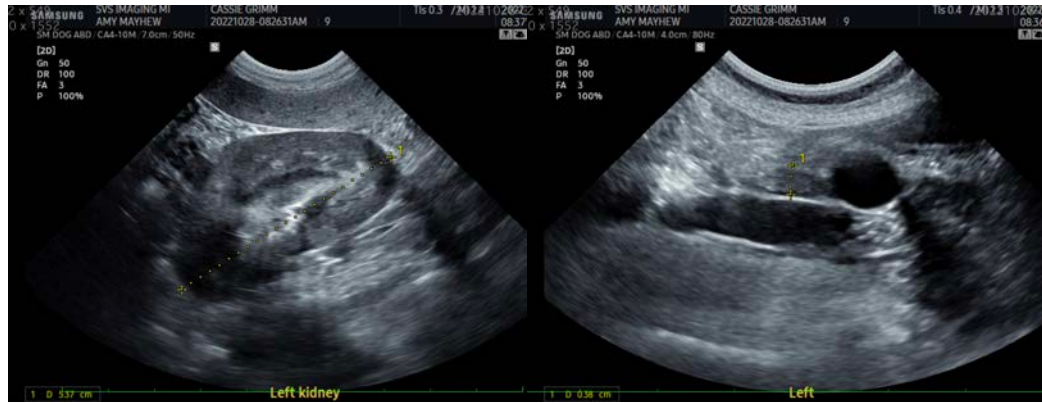
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

Beth Johnson, DVM, DACVIM
Beth.Johnson@sonopath.com